experiences, but that these are not simply models of how other people behave. They are models of one's self *with* another person; models of interaction between people, not static internal images of 'mother' or 'father'. This means that the inner pictures that we draw on to guide our behaviour are images that conjure up how it *feels* to be with another person. If the other person consistently treats you as if you were a fool, you feel like a fool. (You also develop the capacity to treat others as if they were fools.) If your parents show little interest in your states of mind, you feel as if your states of mind are not of interest to others (and probably have little interest in their states of mind either). Of course, as people develop they bring their internal working models to bear on other people too, but in early childhood they are still being formed and are largely shaped by the adults and older children in their life. From later childhood onwards, they will elaborate and rework these early models in various ways.

But in families which neglect or criticise their children too much, there can be a fundamental uncertainty about the worth of the self. The internal working model will be one of inner worthlessness or even badness anticipating a critical or neglectful other. These expectations inform behaviour and often draw others into confirming the expectations, setting up a vicious cycle which is hard to break. Just how difficult will be examined in the following chapters.

Torment

The links between personality disorders and early experience

I looked upon myself like so much garbage, an anomaly, a disgrace, and, what was worse, I believed that I had allowed myself to be overrun by error because of an evil nature.

Marie Cardinal 1984

Being the object of others' negative attention or being disregarded is like an acid which eats away at self-esteem. As we have seen, it can lead to depression or can create a vulnerability to depression if experienced early in life when the personality is forming. But there is a darker form of depression, which is linked to more extreme early experiences, particularly in infancy. This is known in the psychiatric trade as 'borderline personality disorder'. It describes someone who is on the borderline of psychosis, prone to lose their grip on reality and liable to take their inner world for reality. For example, someone who is fearful of another person's motives towards him may believe that she is actually trying to poison him.

There is a whole diagnostic spectrum of personality disorders which have been categorised to give doctors and mental health workers some sense of clarity and predictability in their encounters with people in mental distress. Real individuals don't often fit neatly into such categories. Although these terms are useful insofar as they provide a shorthand form of communication between professionals, I think it needs to be made clear that although couched in the language of disease, the personality disorders are not actual diseases of any kind. In fact, they merely describe typical

features of various points on a continuum of difficulties in regulating and managing emotional life.

The other problem they raise for me is that there is always something demeaning about being described in such terms as 'narcissistic' or 'borderline personality'. The terminology carries a slight sneer, a whiff of contempt with it and to my mind conveys little compassion for the personal history that will inevitably have gone before. Despite all that, I will carry on using these terms because they do conveniently mark out certain territories.

Depression runs through the personality disorders, like a familiar theme in different pieces of music. In both the 'narcissistic' and 'borderline' disturbances of personality, individuals are prone to depression. They share a fragile sense of self that can be disturbed by experiences which more robust people would manage with little difficulty. But the depression of the 'borderline' is less a flattening of feelings and submission to fate than a terrifying roller coaster of emotions. Borderline behaviours are described in textbook terms as including self-destructiveness impulsiveness, dissociation, hostility, shame, ineffectiveness and somatic complaints. To others living better regulated lives, it is apparent that the borderline person has enormous difficulty in regulating feelings. Emotions are on the rampage, often quite out of control.

But the focus on describing the 'symptoms' of the person with a personality disorder inevitably results in distortion. These are not qualities the person was born with, nor are they the sum total of the whole personality. The symptoms are the end results of certain typical histories of parent–child relationships. On this continuum, to think in the most simplified terms, it is likely that the more hurtful these relationships have been, the greater the symptoms are likely to be. The situation is more complex than that, of course, since individual temperaments and circumstances play their part in the outcome, as well as the timing of various events, which can be crucial as we will see. But what can be stated quite categorically is that emotional difficulties such as these are the result of an individual's relationship history.

In particular, the borderline experience may be a disturbance rooted in early infancy. Allan Schore sees the central feature of the borderline experience as growing up in a family which does not help the child to process his own emotional experience well. The child may have a mother there all day long, but the experience is one of 'neglect in the presence of the mother'. The child is buffeted by emotion, experiencing high levels of sympathetic nervous system arousal because his parent figures are in some way physically or psychologically absent or abusive. What is missing is the regulatory partner that the child needs to make sense of his or her experiences and to keep on an even keel through the day. It has been noticed by some commentators that in borderline family histories, the father as well as the mother is usually not accurately tuned in to the child, leaving the child in a state of virtual emotional abandonment.

What kinds of parents do borderline people have?

Most often these are parents who have very few inner resources themselves and find it very difficult to be sensitive to their babies' cues, usually because they are so preoccupied with their own feelings. For example, a baby who is over-aroused by a noisy rattle being waved close to his face, will turn his head away to signal that he has had enough of that particular stimulus. But the unattuned parent may be paying more attention, consciously or unconsciously, to her own inner state of anxiety or distress than to her baby's signal. She might shake the rattle more loudly, thinking that he has just lost interest, instead of responding accurately to the baby's signal and soothing him or offering him something else. As a result, she will increase his (unpleasant) arousal rather than regulating it back to a good state. Of course, such incidents are part of normal parenting and have little effect in a relationship which is mostly attuned, but if this is the chronic state of things, it can affect the baby's regulatory capacities. Worse, if her inner state is one of turmoil and resentment or even hostility to her baby, her capacity to regulate him well will diminish even further.

Lacking self-soothing skills, such parents trying to cope with a baby will be highly stressed. Their nerves are jangled by the baby's crying. The baby's mess is intolerable. There is no time for themselves. Parents in this state who lack helpful family supports may react strongly against the baby, hitting or verbally attacking him, or they may avoid him altogether, leaving him to cry.

The parent of a potential borderline person is often very needy and sensitive to rejection. She may feel that her newborn baby doesn't like her because he is not yet smiling, or perhaps when her baby starts to take an interest in the world around him at around 4 months old, this parent can feel that he is rejecting her. He doesn't seem to need her any more. This can feel very painful since her own emotional needs are so powerfully felt, so unmet. She may retaliate by withdrawing from the baby. The problem is that anyone with powerful unmet needs of her own may find great difficulty in putting the baby's needs before her own, particularly if that does not provide any gratification for her. It can be very hard for her to be a parent in the psychological sense.

Often, such parents have had histories of being neglected or maltreated in their own childhood. They may reject their babies in ways that they too have been rejected. One curious piece of evidence showed that mothers who abuse their young children find it quite aversive to be with them. Alongside the more predictable finding that the mothers' abusive behaviour towards their babies was often triggered off by the baby crying was another finding that was more surprising. These mothers had an unpleasantly high level of arousal not only when their baby cried, but also when the baby smiled at them (Frodi and Lamb 1980). Perhaps they found the demands of a relationship with a baby too much, living with a profound uncertainty about their capacity to regulate their own or the baby's arousal.

Even though such parents might have great devotion to their children, their difficulty in sustaining emotional availability because of their own inner preoccupations tends to make them inconsistent parents. As a result, their children often develop disorganised attachments. This can also happen sometimes in families which are not neglectful

or abusive, but which have had a tragedy of some kind which has not been successfully mourned. Very often, this might be the death of a previous baby, or sometimes the death of the grandparent, which remains in the parent's mind, distracting her from living in the present and attending fully to her baby. The effect on the baby can be rather similar to living with a parent who can't pay attention because of a legacy of inner pain left from her own childhood. In either case, the salient fact is that the baby finds the parent's attention unpredictable and unrelated to his own needs. For example, she might go into a trance-like state, or flinch away from the baby as if the baby is going to hurt her, or suddenly loom into the baby's face too close – behaviours that are frightening to the baby but have more to do with what is going on in the parent's mind than a response to the baby (Solomon and George 1999: 13).

Fear is usually a component of the 'disorganised' baby's experience, perhaps partly because inconsistent care in the first year of life is itself potentially life threatening. Adult patients who may have had these sorts of experiences as infants often describe feelings of falling or disintegrating, suggestive of moments of total regulatory failure.

My clients Norah and her baby Ricky had a volatile relationship which generated these kinds of moments of fear for Ricky. Norah adored her baby when she felt all right, but when her boyfriend let her down and didn't call round when he said he would, she felt so lost and abandoned and enraged that she would treat Ricky viciously, feeding him roughly, shoving the spoon into his mouth in a sadistic fashion, or she would be playing with him and suddenly give in to the urge to pinch his ear very hard, making him cry. Later, she could feel remorse for her behaviour, but she seemed incapable of controlling it. She worried that Ricky wouldn't love her any more because of the way she treated him at times, but still experienced flashes of pure hatred for him as the embodiment of a world that didn't love her enough.

In effect, parents suffering from unmanageable internal pain create a barrier between themselves and their child. Norah's attacks on Ricky made him look at her with the

wariness and anxious fearfulness that made her doubt whether he loved her. Such situations feed on themselves in a vicious cycle, which it is vital to break into at the earliest opportunity. Fortunately, Norah did seek help. By becoming more aware of her own history and the distress that could be so easily triggered in the present, she was able to see Ricky differently and to recognise that he was not the cause of that distress. Prolonged therapeutic work is often needed to help such parents to learn to manage their own states well enough to be able to focus on the baby's needs.

The 'disorganised' baby

But what is it like to be the baby of such a parent? It is very difficult for him to co-ordinate his developing systems with his mother as she is so unpredictable. He can't develop a coherent strategy or game plan with such a parent. He doesn't know whether to turn to her or keep away from her. He needs her, but she may make things worse rather than better. These are the features of a disorganised attachment, as I described in the last chapter.

Disorganised attachments are at the extreme end of the scale of emotional dysregulation, with corresponding effects on the brain. The child is simply not being taught how to manage feelings in any consistent way. He may not have the brain structures to calm himself and cope with distress. Small stresses may escalate into major distress because the orbitofrontal cortex cannot control the arousal of the amygdala and hypothalamus. He may find it difficult to hold back feelings or distract himself when it's necessary to achieve his own goals. This actually leaves the developing child in a rather helpless and dependent state, unable to trust his own responses, constantly looking to other people for cues about how to act and feel. Even though time passes and he looks as if he is growing up, internally he may remain a baby who awaits vital input that would give him the tools to cope with the world.

The kind of neglect that results from having parents preoccupied with their own emotional states can also be very frightening. It is hard to make sense of a world which

has to be navigated without a reliable guide. But the parent may also be frightening because he or she is unpredictably violent, or verbally abusive at times when her own feelings spiral out of control.

According to Marsha Linehan, an American therapist who has pioneered a highly effective treatment programme especially for borderline personality disorders, the borderline person has experienced what she calls an 'invalidating environment' in childhood (Linehan 1993). Its essence is the parents' inability to recognise and respect the child's own feelings and experiences. They may be denigrated because they are an inconvenience to the parents. 'You can't be thirsty, you've just had a drink twenty minutes ago,' the parent will say. Because of her own inability to soothe herself, the parent cannot bear her child being upset. Instead of asking what is wrong, the parent feels so uncomfortable that she says irritably 'stop being a cry-baby'. Such parenting behaviour in effect demands that the child manage his own feelings and punishes the child for a lack of moral fibre if he is not equal to the task. But it does not teach the child how to manage his feelings.

The requirement not to have feelings that your parent finds too demanding may also result in the production of a 'false self', a front which acts like a person but doesn't feel like a person inside. As Marie Cardinal, a French woman who wrote an account of her slow recovery from mental illness, put it:

> I had been fashioned to resemble as closely as possible a human model which I had not chosen and which did not suit me. Day after day since my birth, I had been made up: my gestures, my attitudes, my vocabulary. My needs were repressed, my desires, my impetus, they had been dammed up, painted over, disguised and imprisoned. After having removed my brain, having gutted my skull, they had stuffed it full of acceptable thoughts which suited me like an apron on a cow. (Cardinal 1984: 121)

The narcissistic personality disorder

Patti was a patient of mine who felt that she too was an 'as if' person. She was an active person who enjoyed walking and travel, but had not managed to develop any of her interests into a career. She could not stick at anything long enough to become good at it. She did not say so, but her descriptions of her parents conjured up people who were intolerant of her feelings and needs. They wanted her to grow up as fast as possible and had not enjoyed her being a dependent baby. She had not been breastfed. If she cried out at night, her mother didn't come. Her mother's needs came first. She could not wait to get away from the children, to shop for nice clothes, have an affair, enjoy her holidays. Someone else was always left on the beach with the children. She was not very interested in them or their company. Worse, when Patti inconvenienced her, for example, by knocking over a special vase that her mother had forgotten to put away, her mother would lash out with fury and hit her. She was frequently punished. Patti grew up feeling she was clumsy and stupid, and focused on trying hard to please others by being helpful. She attempted to be a sensible, grown-up person, yet inside she always felt like a little girl in a world full of grown ups, Alice in Wonderland, lost without the rule book. She would try to have the feelings she thought were expected of her, but she had great difficulty in knowing what she was really feeling. Negative feelings about other people were particularly taboo. This story is typical of the experiences of a 'narcissistic personality disorder' – the kind of experience which might lead to a vulnerability to depression.

The narcissistic or 'neurotic' person is often described in terms of attempts to manage without other people. Various writers have attempted to define narcissism, but most agree on the typical symptoms of narcissism as:

- self-consciousness and shame (extreme reactions to being criticised)
- an inflated sense of self (grandiosity)
- not knowing who you are, being out of touch with feelings

- fear of others' envy
- the illusion of self-sufficiency
- sado-masochism and hidden anger (based on Mollon 1993).

Most of these categories involve the kind of instability involved in not being well connected to others and not being able to use them to help regulate feelings. Feelings of personal power and agency fluctuate, so that at times the individual feels capable of great things without any help, and at other times feels that others will hurt or destroy him. (Is manic depression perhaps an extreme form of this state, perhaps found in people with an intense disposition who find it particularly hard to be self-sufficient?)

Allan Schore believes that problems in the narcissistic spectrum have their roots in toddlerhood. He thinks that people with these sorts of difficulties probably had good enough care as babies to have a coherent body image and even to feel very good about themselves at times, as excited toddlers do, but he suggests that they have not had the kind of parenting that would help them to manage shame and the recovery from shame.

Many parents do well at the baby stage, unlike the parents I have just described as potential parents of 'borderline' people. They are able to enjoy their babies because they feel needed and powerful. The baby can be experienced as an extension of the mother's body and is largely under her control. However, when their child becomes a toddler with a mind of his own and a body that comes under his own control, they may not enjoy parenting as much. The mother wants a compliant child who fits in with her and meets her needs – possibly one who does not grow up and become separate. She does, in a sense, want to take over the child (see above, the narcissistic adult's fear of being taken over).

This kind of parent might forge an insecure attachment with her child. She may be an inconsistent mother who can be totally in tune with the child one moment, but withdrawn, bored, or unattuned the next; or she may be a more consistently resentful and reluctant mother, as Patti's seems to have been.

Despite these different pathways, Allan Schore has suggested that humiliation is a central issue that links those in the narcissistic spectrum. He thinks that its 'symptoms' arise largely from the poor regulation of shame. During toddlerhood, important aspects of socialisation are taking place, facilitating important brain development. As I have already described in Chapter 2, the orbitofrontal area of the prefrontal cortex becomes connected up to the parasympathetic nervous system. This enables the child to begin to be able to inhibit his own behaviour. He is taught what is acceptable and what is not, through a withdrawal of parental attunement. When he does something that parents don't like, they convey their disapproval and negativity which is stressful and unpleasant. The child experiences humiliation and is flooded with cortisol.

Although this may be inevitable in learning social rules, what is vital is for the ruptured relationship to be quickly repaired before the feeling of continuity of the good relationship is lost. This is a matter of judgement, and can perhaps be extended in time as the child gets older. But small children, who need much more continuous regulation, cannot afford to lose the thread of their regulatory relationship. At a physiological level, they need to restore the warm connection with their parent in order to disperse the cortisol and other stress hormones and regulate back to a normal set point.

Parents who are not good at regulating their toddlers may leave the toddler in a distressed state for too long. They may be parents who have difficulties in bearing negative feelings, so they may attempt to distance themselves from the child's feelings instead of entering into them and 'containing' them. These parents often tease or humiliate a child in a state of shame, saying things like 'I can see why they picked on you in the playground' or 'Don't be so wet'. If the child is angry, instead of containing the anger the parent may escalate it – 'Don't you talk to me like that!' Equally, the parent may have difficulty responding to the toddler's excitement and joy, in meeting it and sharing it, and regulating it to a manageable level. With these kinds of regulatory difficulties, over time the child may lose confidence in his relationship

with the parent and in its basic goodness and capacity to regulate him. As we have seen in the previous chapter, he may become prone to depression – easily plunged into dysregulation by a current humiliation or loss, because his stress response is oversensitised during toddlerhood.

Along the spectrum towards abuse

Although this was true of Patti's toddlerhood, there was also a deeper undertone in Patti's experience, which was more difficult to get at and to put into words. There were hints that her problems did not just originate in her toddler experience, but went further back to the beginning of her life as a baby. Her mother had found her difficult to breastfeed. She didn't hold her very much. There were incidents which suggested that her mother was actively hostile towards her early on – an incident of hypothermia when she had been left out in her pram for too long, being told she was an ugly baby. Later, at the start of her own adolescence, she became aware of her mother's continuing hostility when they were on a camping holiday and she was forced to wash her mother's blood-stained knickers in public. But such memories were few and her conscious awareness and ability to put these things into words was limited.

However, in her relationship with her therapist, Patti wordlessly conveyed many things about her early life, in particular her deep ambivalence towards women. Her wiry, restless body conveyed tension: she tended to treat the therapist as a social acquaintance whom she was chatting to at a bus stop, relaying the week's events, rather than as an intimate regulatory partner whom she could trust to understand and manage her more difficult feelings. She was critical of the therapy too, but a punctual, regular attender who tended to fall to pieces when there was a holiday break. She frequently toyed with the possibility of other therapies or threatened to break off the work because she couldn't afford it, echoing the fear of abandonment that her mother had generated in her. These experiences suggested that Patti had mildly borderline aspects to her history. With borderline

patients, the therapeutic relationship is often the most potent evidence of the inner world that was created through this person's early life experience, since it is a *lack* of trust and a *lack* of expectation of regulation that is the painful core of the person's life.

Many researchers have linked the borderline condition with sexual abuse, which was not something that Patti had experienced. Although there does seem to be a strong link (Linehan suggests that as many as 75 per cent of borderline patients may have been sexually abused whilst other studies suggest much lower figures), it may not be the key factor in the borderline experience. One of the most recent studies of borderline personality disorder found that 71 per cent of borderline individuals had been emotionally abused, with some overlaps with physical and sexual abuse (Posner and Rothbart 2000).

I would agree with Linehan that it is probably not the sexual abuse alone which derails people. Sexual abuse may be a side effect of a dysfunctional, invalidating family, or even a 'marker' of the severity of family dysfunction (Zanarini *et al.* 1997). As Zulueta has pointed out, abuse is a 'specialised form of rejection' (Zulueta 1993). What matters is that the child's emotional needs are not attended to – but the borderline state seems to involve the double whammy of the child depending on someone who isn't reliably there for him emotionally *and* who actively abuses or rejects him in some way. This is highlighted by the life story of the American poet, Anne Sexton.

Anne was the youngest of three daughters, born to a prominent businessman father and a mother who liked writing and socialising – a wealthy, Scott Fitzgerald type of party-loving, boozing family. But the parents were both extremely unpredictable emotionally. As Jane, one of Anne's sisters, said: 'Daddy was either drunk or he was sober, but you never knew, with Mother, when she was going to be horrible or nice. The minute you thought you knew where you were, she'd turn on you.' Anne also remembered how 'mean' Daddy could be when he was drunk: 'He would sit and look at you as though you had committed some terrible crime' (Middlebrook 1991). His put-downs included complaints that

her teenage acne disgusted him: 'I can't eat when she's at the dinner table,' he said, whilst Mother disparaged her writing, sending her teenage poems off to an expert to check whether she was plagiarising someone.

From infancy, Anne and her sister were supervised by a nurse who was described as tough and reserved. She managed their appearance and their manners. They were dressed up to join their parents for dinner or to be presented at a party, but did not see a great deal of their mother, whom they adored. Anne grew up shy and lonely, describing herself as 'a nothing crouching in the closet'. Although she found it hard to get any positive attention from her mother, she did get negative attention and humiliation. When she was about 4 years old, her mother used to inspect her genitals 'saying how we had to keep it clean and mustn't touch'. Her bowel movements were also inspected on a daily basis and she was threatened with a colostomy at the age of 12 if she didn't 'go'. She ended up being hospitalised for severe constipation.

One relationship seemed different – with great aunt Anna, who had been closely involved with the family throughout Anne's childhood and was openly affectionate towards Anne. She moved in with the family when Anne was 11 and Anne spent huge amounts of time with her: eating lunch with her, playing cards in her room, doing homework with her, going to the movies with her after school, and having her 'daily cuddle with Nana' when they lay together in bed. The evidence appears to be that this was a sexual contact too; Anne later sexually abused one of her own daughters (Magai and Hunziker 1998: 384). Nana had no adult sexual partner and perhaps sought comfort from Anne which she could not find elsewhere, or perhaps she was seeking to discharge her sexual tension or her anger, using the child as a vehicle for some unresolved emotional dynamic of her own. Whatever her motives, the adult abuser fails to recognise the child's emotional needs, putting her own first. Of course children like Anne who are emotionally needy and unprotected by their own parents are easy to manipulate into sexual situations.

One consequence for the sexually abused child is that she (or he) may feel that there is nowhere to turn for comfort,

as Felicity de Zulueta has pointed out. The fact that sexual abuse is taking place within the family means that the child has lost the protection of both parents, not just of the perpetrator. An overwhelming, physiologically arousing event has taken place without any means of regulating it. Those borderline personalities who have experienced this kind of childhood abuse tend to have a hyper-reactive stress response (Rinne *et al.* 2002).

Children like Anne are normally biased to high sympathetic nervous system arousal. They are used to high levels of negative affect and a hyperactive subcortex because of the physical or emotional abuse they suffer. Yet because they don't have a well-developed orbitofrontal cortex, they lack the capacity for restraint based on connections to the parasympathetic nervous system. Their right brains may also have a blunted capacity to regulate emotion because their dopamine receptors are less sensitive (Schore 2003). This makes them prone to become overwhelmed by intense feelings such as anger. As Horowitz described it: 'Not thinking, all feeling. He wants to demolish and destroy persons who frustrate him. He is not aware of ever loving or even faintly liking the object. He has no awareness that his rage is a passion that will decline. He believes he will hate the object forever' (Horowitz 1992, quoted in Schore 2003).

Anne Sexton had lifelong problems of emotional regulation. When she felt overwhelmed by intense states, she either used alcohol or sleeping pills to tranquillise herself, or she went into 'trances' where she stared ahead for hours at a time, dissociated from her feelings altogether. Dissociation is one of the most primitive defences against mental pain – a crude attempt to cut off contact with other people who might generate further (unpleasant) sympathetic nervous system arousal. People in a dissociated state have activated the dorsal vagal complex in the brainstem, bringing about a physiological slowdown, with decreased blood pressure and heart rate, like animals who 'play dead' when caught by a predator. This is known to be a psychological defence often used by children with a 'disorganised' attachment. When you do not know whether to approach or avoid, you 'flee inwards' (Schore 2003).

Encouraged by her psychotherapist to write, Anne Sexton attempted to use her poetry as well as her therapy to regulate herself more constructively. Her poetry brilliantly articulated her intense and extreme feelings and she became a successful poet, winning recognition and even adulation from men and women, with whom she had many sexual affairs. The tensions involved in borderline histories often produce great creativity. But when her therapist abruptly terminated her treatment, she committed suicide, aged 46.

A child who suffers these kinds of experience is not only being physically harmed, but is also being poisoned with the parent's toxic beliefs about relationships. Survivors have testified that the physical harm that has been done to them is not necessarily the main impact of the experience. As one woman put it, 'I can accept that I was hit and raped, but I can't get over being hated' (Chu 1998: 12). The feeling of being a mere thing for someone else's use drains the self of meaning and value. If your parents don't love you, what are you worth? Anne Sexton gave voice to this feeling of having only transitory worth for others in one verse:

> Let's face it, I have been momentary.
> A luxury. A bright red sloop in the harbour.
> My hair rising like smoke from the car window.
> Littleneck clams out of season.
>
> (Sexton 2000)

The black hole

Dehumanisation and lack of emotional value is at the heart of the borderline relationship from the start. From the start, the parents have difficulties in recognising their baby as an intentional being with mental states. Peter Fonagy, one of the most important researchers in the field of attachment who has studied borderline issues, places a great deal of emphasis on what he calls 'mentalising' – the capacity to recognise other minds. He suggests that the borderline person grows up avoiding thinking and mentalising because it would involve recognising this hatred or lack of love in his parents' attitude to him. But blanking out the maltreatment

and thoughts about it makes it impossible for the person to find any way of recovering from it (Fonagy *et al.* 1997).

It is true that severely borderline people have difficulty thinking about their experiences, particularly their experiences with their parents. It is unbearable to know that your parents disregarded your feelings and may even have hated you in some way. This makes the therapeutic process a very difficult task. It is true that borderline people do need to understand what has happened to them and they will find it difficult to have a secure sense of self until they can face the painful nature of their childhood experiences and find a way of accepting them. Nevertheless, Fonagy's emphasis on mind-mindedness and the verbal articulation of feelings tends to underplay the importance of infancy in my view. It does not give sufficient weight to the basic difficulties with regulating feelings that people in the borderline category invariably experience; difficulties that I agree with Allan Schore originate in the baby's experience of being unregulated.

The feelings that are experienced by borderline people evoke the intensity and terror of a helpless, uncared for baby. At its worst, the borderline sometimes falls into what has been called the 'black hole of shame', a non-verbal state of blankness; timeless, spaceless horror. It is linked to feelings of falling into the void – of not being safely held, contained, in a mother's arms. The borderline person is overwhelmed by negative feelings and tends to have what others experience as an exaggerated response. When things are going badly, everything is bad, there is no possible end to badness. He feels he himself is bad. His feelings are shameful since no one can understand them or wants to know them. He loathes himself. Past good feelings don't exist and can't be recalled. As Patti said to me once, 'I can't keep good experiences in.' Good feelings run through the fingers like sand, perhaps because nothing good can be trusted in a world where parents have been so ambivalent towards you. This inability to make use of advice or support is particularly characteristic of the borderline condition.

It's as if there is not enough of a 'self' there to process the experience – 'self' in the sense of a regulatory self. After all, 'selfhood' is very tied up with the ability to manage emotions in a consistent way that others can recognise and comment on. When others notice that 'you're always so calm/controlling/persistent/quick to act/absent-minded/ stoical or practical', they are commenting on your style of emotional management. The sense of self is very dependent on this feedback from others. We need to know how others see us and to develop a consistent 'personality' or style of emotional management. But if the parental response is consistently negative or absent, we can feel 'wiped out', invalidated and basically bad. It becomes much harder to think about feelings without a framework of ongoing support and the sense of self becomes increasingly tenuous.

My patient Dilys was in her forties, yet lived in a state of near confusion and regulatory chaos. When she came to see me, she would endlessly question her behaviour, muttering at a fast pace, 'I shouldn't have come in a car, I can't afford the petrol, I should have walked. Why did I do that?' she would wail. "My daughter wants me to get her a dress for her birthday but I don't know what to choose for her – I can't decide – I can't think. I thought I should get something pink but now I don't know if pink suits her. Is pink a good colour? Her father doesn't like pink. I should have got her to bed last night instead of watching the film. I'm stupid – the film wasn't that good. Her teacher looks down on me, she thinks Elly is always tired. I know I'm a terrible mother. I forgot to give her a bath this morning, but you don't need a bath every morning do you?" – and so on – and on. Dilys had no bearings on her own reality that were rooted in her own feelings. She acted impulsively and she spoke impulsively, without an organising principle that would allow her to prioritise her experiences and make choices about how to act. For most of us, the organising principle is our feelings and the meaning we attribute to them. But Dilys didn't know what she felt. Her constant attacks on herself were an invitation in a way to sort her out. She conveyed the helplessness of a baby, who needed someone somewhere to look after her and make sense of it all. She herself was the daughter of an alcoholic mother and a criminal father, and had been sexually abused by her uncle as a child.

Lacking adequate regulatory mechanisms, she was prone to panic, particularly when she felt abandoned by other people. The borderline person usually has a desperate fear of rejection or abandonment. This may be because he remains heavily dependent on other people to regulate him. There are usually key relationships which provide just enough regulation to keep going – but when they are threatened, or he imagines they are threatened, it feels as if the world is falling apart. At this point, the borderline person has to rely on his own means of self-regulation, which are often very crude. He tends to act impulsively and destructively. Because he has inadequate mental regulatory strategies, he tends to try to manage feelings through direct action – jumping in a car and driving 100 miles an hour to relieve inner tension, or slamming the phone down when angered by a conversation. He may cut himself to relieve the mental pain, or try to blot it out with sleep or drugs or alcohol. When Dilys's mother died unexpectedly, she kept going to the local railway station, thinking about jumping onto the rails.

Many borderline behaviours are self-destructive rather than destructive of others, although they often do impact on others' lives in a negative way. But in the next chapter, I will consider how criminal behaviour may also be a form of borderline behaviour in some instances, which manages the rage produced by early mistreatment very differently – by attacking others.

Original sin

How babies who are treated harshly may not develop empathy for others

The violent children of the future are now babies.

If you meet a teenage mugger on the street one night, the last thing that you will be thinking about is his infancy. But the fear and rage evoked in you are probably the same feelings that have been with him since babyhood, which have been instrumental in transforming this particular baby into an antisocial thug. His actions succeed in infecting his victims with his own fear and anger.

As victims or potential victims, we retaliate, with thoughts of punishment and imprisonment. The language we use conveys our rejection and repulsion. We refer accusingly to the yob, vandal, thief, bully, hooligan, robber, murderer. They are words that conjure up fearful images of a foul-mouthed young man who spits, carries knives, menaces others and threatens our safety. Our attitude seems to be: he clearly doesn't care about other people – so why should we care about him? It is very hard to even bother to imagine that this menace was once a baby. The more serious his violence, the further away from human concern he gets. The young man who shoots a stranger in the street for his mobile phone or the teenager who stamps on an old woman's face to take her meagre savings are beyond our comprehension. How can they lose sight of the humanness of another person to such a degree? One answer, supplied by Peter Fonagy, is that they have not had the meaningful attachment relationships in early life that would allow them to identify with others (Fonagy *et al.* 1997). Other people's feelings do not seem real